DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

May 31, 1988

ALL-COUNTY LETTER NO. 88-50

TO: ALL COUNTY GAIN COORDINATORS
ALL COUNTY WELFARE DIRECTORS

SUBJECT: WORKERS' COMPENSATION INSURANCE COVERAGE FOR PARTICIPANTS IN A PREEMPLOYMENT PREPARATION (PREP) ASSIGNMENT

REFERENCE: MPP Sections 42-730.3 and 42-740.15

Effective April 1, 1988, individuals in the Greater Avenues for Independence (GAIN) program participating in a PREP assignment will be covered for workers' compensation insurance as required by Welfare and Institutions Code Section 11320.7 and Manual of Policies and Procedures Section 42-740.15 through self-insurance by the State Department of Social Services (SDSS). The Insurance Officer of the State of California, acting on behalf of SDSS, has contracted with the State Compensation Insurance Fund (SCIF) to adjust workers' compensation claims. The cost of purchasing separate insurance coverage or self-insurance by individual Counties will no longer be permitted.

If a County has paid for any workers' compensation claims for an accident involving a PREP participant occurring on or after April 1, 1988 and prior to receipt of this All County Letter, the County should send all of the relevant case material (e.g., Employer's Report of Occupational Injury or Illness, medical reports and bills) to the appropriate district State Compensation Insurance Fund Adjusting Office. The State Compensation Insurance Fund will, during the course of normal business, reimburse the County for any actual cost of benefits paid to PREP participants.

Effective immediately, if a PREP participant is injured while performing his or her assignment, a claim form must be submitted to SCIF in accordance with the following guidelines:

1. Claim forms are to be completed by a responsible individual in the public agency or non-profit organization where the participant is assigned within 24 hours of occurrence or knowledge of the occurrence of injury. If the location of the assignment is other than the County Welfare Department (CWD), a copy of the claim must be forwarded simultaneously to the CWD.

   It is the CWD's responsibility to ensure that the forms are promptly and correctly completed and forwarded to the appropriate office of the State Compensation Insurance Fund. The mailing addresses of the State Compensation Insurance Fund adjusting offices are listed on the reverse side of the claim form, SCIF 3067 STATE (Rev. 4-87), a sample copy of which is attached to this All-County Letter.

2. A list of all Counties showing the office and telephone number of the State Compensation Insurance Fund that claim forms should be sent to, and the County location code to be entered for Question 3A on the forms, is also attached to this All-County Letter.

   All work related injuries of PREP participants must be submitted to SCIF on the Form SCIF 3067 STATE (Rev. 4-87). A supply of the forms for Counties' use should be obtained immediately by contacting the State Compensation Insurance Fund Adjusting Office listed for your area on the attached County location code list.

   The claim form itself is very similar, if not identical, to ones that all employers, including each County, fill out when one of its salaried employees is injured while working. With the following exceptions, the questions are self-explanatory. The exceptions are:

QUESTION 1	This should be the name of the agency where the participant is assigned, preceded by the acronym for the program, "GAIN".
QUESTION 1A	A constant for all claims; P.A.C. or SCIF Policy Number 997.
QUESTIONS 2, 2A, 3, 4A and 4B	These should reflect data relating to the public agency or nonprofit organization.

QUESTION 3A	Location Code ____ (Enter three digit County identifier (see attachment) of the location where participant is assigned.
QUESTION 5	Not applicable.
QUESTIONS 13C and 14	Not applicable.
QUESTIONS 28 and 29	The boxes should be checked "no".

3. If a PREP participant is killed, or sustains a serious injury, the designated responsible individual in the agency should immediately call the appropriate State Compensation Insurance Fund Office. (See telephone numbers for SCIF offices on the attachment containing County location codes). If the agency is other than the CWD, the responsible individual must immediately call the CWD as well.

If you have any questions related to completing the forms, please contact Mr. Eugene D. Marquart, the State Insurance Officer in the State Department of General Services at (916) 323-3867. If you have any other questions regarding the information in this letter, please contact your GAIN County Operations Analyst at (916) 324-6962.

DENNIS J. BOYLE
Deputy Director

Attachments

ATTACHMENT TO ALL-COUNTY LETTER 88 - 50

LIST OF COUNTY LOCATION CODE AND STATE FUND OFFICES

COUNTY	LOCATION CODE	STATE FUND OFFICE	TELEPHONE
(For mailing addresses, see reverse side of SCIF 3067 claim form.)			
ALAMEDA	010	OAKLAND	(415) 638-1500
ALPINE	020	STOCKTON	(209) 951-8000
AMADOR	030	STOCKTON	(209) 951-8000
BUTTE	040	REDDING	(916) 243-8400
CALAVERAS	050	STOCKTON	(916) 951-8000
COLUSA	060	SACRAMENTO	(916) 924-5100
CONTRA COSTA	070	OAKLAND	(415) 638-1500
DEL NORTE	080	EUREKA	(707) 443-9721
EL DORADO	090	SACRAMENTO	(916) 924-5100
FRESNO	100	FRESNO	(209) 445-5856
GLENN	110	REDDING	(916) 243-8400
HUMBOLDT	120	EUREKA	(707) 443-9721
IMPERIAL	130	SAN DIEGO	(619) 560-1600
INYO	140	SAN BERNARDINO	(714) 884-7284
KERN	150	BAKERSFIELD	(805) 834-8300
KINGS	160	FRESNO	(209) 445-5856
LAKE	170	SANTA ROSA	(707) 576-2601
LASSEN	180	REDDING	(916) 243-8400
LOS ANGELES	190	*	
MADERA	200	FRESNO	(209) 445-5856
MARIN	210	SANTA ROSA	(707) 576-2601
MARIPOSA	220	STOCKTON	(209) 951-8000
MENDOCINO	230	SANTA ROSA	(707) 576-2601
MERCED	240	STOCKTON	(209) 951-8000
MODOC	250	REDDING	(916) 243-8400
MONO	260	STOCKTON	(209) 951-8000
MONTEREY	270	SAN JOSE	(408) 297-1714
NAPA	280	SANTA ROSA	(707) 576-2601
NEVADA	290	SACRAMENTO	(916) 924-5100
ORANGE	300	SANTA ANA	(714) 567-2800
PLACER	310	SACRAMENTO	(916) 924-5100
PLUMAS	320	REDDING	(916) 243-8400
RIVERSIDE	330	SAN BERNARDINO	(714) 884-7284
SACRAMENTO	340	SACRAMENTO	(916) 924-5100
SAN BENITO	350	SAN JOSE	(408) 297-1714
SAN BERNARDINO	360	SAN BERNARDINO	(714) 884-7284
SAN DIEGO	370	SAN DIEGO	(619) 560-1600
SAN FRANCISCO	380	SAN FRANCISCO	(415) 565-1234
SAN JOAQUIN	390	STOCKTON	(209) 951-8000
SAN LUIS OBISPO	400	VENTURA	(805) 644-4300
SAN MATEO	410	SAN FRANCISCO	(415) 565-1234
SANTA BARBARA	420	VENTURA	(805) 644-4300
SANTA CLARA	430	SAN JOSE	(408) 297-1714
SANTA CRUZ	440	SAN JOSE	(408) 297-1714
SHASTA	450	REDDING	(916) 243-8400
SIERRA	460	SACRAMENTO	(916) 924-5100
SISKIYOU	470	REDDING	(916) 243-8400
SOLANO	480	SACRAMENTO	(916) 924-5100
SONOMA	490	SANTA ROSA	(707) 576-2601
STANISLAUS	500	STOCKTON	(209) 951-8000
SUTTER	510	SACRAMENTO	(916) 924-5100
TEHAMA	520	REDDING	(916) 243-8400
TRINITY	530	REDDING	(916) 243-8400
TULARE	540	FRESNO	(209) 445-5856
TUOLUMNE	550	STOCKTON	(209) 951-8000
VENTURA	560	VENTURA	(805) 644-4300
YOLO	570	SACRAMENTO	(916) 924-5100
YUBA	580	SACRAMENTO	(916) 924-5100

*Generally speaking, Los Angeles claims should be sent to the closest office to where the GAIN recipient works as follows:

San Fernando Valley, North L.A. County	-	Woodland Hills	(818) 888-4750
West Los Angeles	-	Culver City	(213) 670-3623
Downtown Los Angeles	-	Los Angeles	(213) 385-1531
Long Beach Area	-	Cerritos	(213) 402-8600
San Gabriel Valley	-	Arcadia	(818) 445-4030

PLEASE TYPE ALL INFORMATION IN BLOCKS

State of California

EMPLOYER'S REPORT

OF OCCUPATIONAL

INJURY OR ILLNESS

Please complete in triplicate. Retain one co or your files and mail the original and one copy to

STATE COMPENSATION INSURANCE FUND

Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 3581.2 — 3581.5 for instructions on completion and routing.
BOTH SIDES OF THIS FORM MUST BE COMPLETED

OSHA Case or File No.

PICA XXX ELITE XXX ← TYPEWRITER ALIGNMENT GUIDE → PICA YYY ELITE YYY

California law requires an employer to report within five days every industrial injury or occupational disease which: (a) results in lost time beyond the day of injury or (b) requires medical treatment other than first aid. PLEASE NOTE: In addition, if death results or if the injury or illness: (a) requires inpatient hospitalization of more than 24 hours for other than medical observation; or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement then the nearest district office of the California Division of Occupational Safety and Health also must be notified **immediately** by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYER

1. DEPARTMENT — DIVISION — 1A. P.A.C. OR SCIF POLICY NUMBER

2. MAILING ADDRESS (Number and Street, City, ZIP) — 2A. PHONE NUMBER

3. LOCATION, IF DIFFERENT FROM MAIL ADDRESS (Number and Street, City, ZIP) — 3A. LOCATION CODE

4A. NATURE OF BUSINESS e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. — 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.

4B. TYPE OF EMPLOYER: PRIVATE STATE CITY COUNTY SCHOOL DISTRICT OTHER GOVERNMENT — SPECIFY

EMPLOYEE

6. EMPLOYEE NAME — 7. DATE OF BIRTH (MM-DD-YY)

6. HOME ADDRESS (Number and Street, City, ZIP) — 8A. PHONE NUMBER

9. SEX: Male Female — 10. OCCUPATION (Regular job title, not specific activity at time of injury) — 11. SOCIAL SECURITY NUMBER

12. DEPARTMENT IN WHICH REGULARLY EMPLOYED — 12A. DATE OF HIRE (MM-DD-YY)

13. HOURS USUALLY WORKED: HOURS PER DAY — 13A. DAYS PER WEEK — 13B. TOTAL WEEKLY HOURS — 13C. Under what class code of your policy were wages assigned?

14. GROSS WAGES/SALARY: PER: HOUR DAY WEEK TWO WEEKS MONTH OTHER — SPECIFY

INJURY OR ILLNESS

15. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and Street, City) — 15A. COUNTY — 15B. ON EMPLOYER'S PREMISES? YES NO

16. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)

17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g., the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the thing he was lifting, pulling, etc.

19A. DESCRIBE THE INJURY OR ILLNESS e.g., cut, sprain, fracture, skin rash, etc. — 19B. PART OF BODY AFFECTED e.g., back, left wrist, right eye, etc.

20. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)

21. IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)

22. DATE OF INJURY OR ILLNESS (MM-DD-YY) — 23. TIME OF DAY a.m. p.m. — 24. Did employee lose at least one full day's work after the injury? (MM-DD-YY)
NO YES — Date Last Worked:

25. HAS EMPLOYEE RETURNED TO WORK? (MM-DD-YY) — 26. DID EMPLOYEE DIE? (MM-DD-YY)
No, still off work Yes, date returned: NO YES — Date of Death:

27. WAS ANOTHER PERSON RESPONSIBLE? NO YES — 28. PERS/STRS MEMBER NO YES — 29. ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING TEMPORARY DISABILITY BENEFITS? NO YES

PLEASE DO NOT USE THIS COLUMN

CASE NO.

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

ACCIDENT TYPE

A.O.S.

EXTENT OF INJURY

CODED BY

Completed by (type or print)	Signature	Title	Date

SCIF 3067 STATE (REV. 4-87) FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. NOTICE OF WORKERS' COMPENSATION BENEFITS MUST BE GIVEN TO INJURED WORKER WITHIN 5 DAYS OF YOUR KNOWLEDGE OF THIS INJURY.

FORM 5020 (REV. 5) Apr. 1987